NEW HAMPSHIRE VOICES FOR HEALTH

December 30, 2014

Via Electronic Submission

Sylvia Matthews Burwell, Secretary, US Department of Health and Human Services
Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard, MS-S2-26-12
Baltimore, MD 21244-1850
Submitted via: Medicaid.gov

Re: Comments on the New Hampshire Health Protection Program Premium Assistance Waiver Application

Dear Secretary Burwell and Administrator Tavenner:

NH Voices for Health ("VOICES") is pleased to submit these Comments on New Hampshire's Medicaid Section 1115 Research and Demonstration Waiver Application, entitled *New Hampshire Health Protection Program Premium Assistance* (and hereinafter referred to as the "proposed Waiver" or "Waiver Application").

VOICES is a non-partisan, statewide network of organizations and individuals allied in the commitment to quality affordable health care and coverage for residents of New Hampshire, and representing more than 380,000 members and constituents across the Granite State.

First, we want to commend the NH Department of Health and Human Services ("DHHS" or "Department") and the NH Insurance Department ("NHID") for their diligent and successful efforts to implement expanded Medicaid in New Hampshire via the NH Health Protection Program ("NHHPP").

With more than 29,000 New Hampshire residents enrolled in the NHHPP bridge program since August 15 of this year, this expansion of health coverage is a significant step forward for our state, successfully promoting:

- Access to essential health services for hardworking, lower-income Granite Staters;
- Reductions in uncompensated care for health care providers;
- Reduced burden on a business community that, with health care cost-shifting, has been faced with rising health coverage expenses; and, as a result,
- A healthier workforce, fortified health system, and strengthened state economy.

The NHHPP authorizing statute requires New Hampshire to apply for a Section 1115 Waiver that would transition all NHHPP bridge program enrollees to a premium assistance program, to Medicaid-financed enrollment on New Hampshire's federally-facilitated Marketplace, effective January 1, 2016.[1] After state-level public process, the Department's Waiver application to CMS is pending effective December 1, 2014.

We have a handful of concerns and suggestions for your consideration regarding the proposed Waiver.

[1] RSA 126-A:5, XXV (a) and (b).

1. *Proposed One-Year Waiver Timeline.*

VOICES respects and appreciates that the NH Health Protection Program is scheduled to sunset at the end of calendar year 2016 *unless it is extended / reauthorized by New Hampshire's Governor and Legislature.*[2] As a result, the Waiver application proposes a one-year timeline for the Waiver.

However, we encourage CMS to provide for a three-year Waiver timeframe, with a circuit-breaker provision articulating that the Waiver program will end after one year in the event that the NHHPP is not reauthorized by New Hampshire[3].

There are three important reasons for this suggestion: proof of the proposed Waiver hypotheses; required budget neutrality; and government efficiency.

First, one year appears to be an insufficient time period to gather the comprehensive data needed and required to prove the proposed Waiver's thoughtful and well-crafted demonstration hypotheses for New Hampshire's Premium Assistance Program (see Waiver application, at pages 4 through 6). This is one of the most important reasons, of course, that Section 1115 research and demonstration Waivers are ordinarily three to five years in duration.

Second, there are start-up costs associated with getting a successful, inherently ambitious Premium Assistance Program ("PAP") off the ground in the first year, ramp-up time during which it will be harder to accomplish any program savings. A one-year Waiver appears far less likely to achieve required 'budget neutrality' than a three-year Waiver, which can and would spread the Program's costs and savings out over time. This is another sensible reason that Section 1115 Waivers ordinarily are three to five years in length.

Third, in the event that the NH Health Protection Program is reauthorized, and with only a year-long Waiver, DHHS *and* CMS would be required to expend the time, energy, and effort needed for a Section 1115 Waiver renewal / extension. Given the availability of a workable three-year Waiver timeline coupled with a pragmatic circuit-breaker provision, at a time when government efficiency and cost-effectiveness are paramount, requiring such future effort by the Department and by CMS would not appear to be a helpful or prudent exercise of valuable and limited government resources.

We encourage you to provide for and approve a three-year Waiver timeline, with an appropriate and workable circuit breaker provision.

2. *Proposed Waiver of Medicaid's 90-Day Retroactive Coverage Requirement.*

The Waiver application proposes that Premium Assistance Program coverage begin on the enrollee's date of application (or on January 1, 2016, whichever is later).

It is sound public policy to ensure that Medicaid's 90-day retroactive coverage protection continues for NHHPP Premium Assistance Program enrollees. The retroactive coverage

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[2] RSA 126-A:5, XXV (a) and (c).

[3] If New Hampshire fails to reauthorize the NHHPP, we believe this would be true as a matter of law.

period in Medicaid law avoids unnecessary medical debt, reduces uncompensated care costs, and alleviates financial burden on patients as well as providers.

Retroactive coverage also serves as an important incentive for health provider participation in the NHHPP, helping to ensure sufficient provider engagement to satisfy requirements concerning health care provider network adequacy and patients' timely access to care.

It is worthy of special consideration that any effort to achieve budget neutrality with an unnecessarily abbreviated one-year Waiver timeline (see above) is a misplaced and legally insufficient reason to waive this fundamental 90-day retroactive coverage protection for consumers, providers, and the health system.

We urge you to maintain the 90-day retroactive coverage protection for NH Health Protection Program enrollees.

3. *Grievances and Appeals.*

When it comes to grievance process concerning Premium Assistance Program health services or benefits coverage, the proposed Waiver provides that enrollees will be required to use two separate and independent appeals procedures:

- The qualified health plan (QHP) / private insurance appeals process for grievances or denials concerning QHP benefits, including medical necessity determinations; and
- The Medicaid appeals process for grievances or denials concerning Medicaid wrap-around benefits.

While PAP enrollees will be provided (Medicaid-financed) health insurance through QHPs, they will remain Medicaid beneficiaries entitled to due process rights afforded them under federal law. Carefully crafted to meet the health care and coverage needs of lower-income and vulnerable people, the appeals provisions in federal Medicaid law are designed to ensure that such persons are not denied health coverage or benefits without appropriate process and lawful reason.

We remain concerned that the QHP appeals process may afford insufficient due process protection to be substantially equivalent to the Medicaid fair hearing requirements provided in federal law[4] and enunciated by the U.S. Supreme Court[5]. We also have concerns that the QHP appeals process may be unduly burdensome for vulnerable PAP enrollees who face challenges such as limited English proficiency, illiteracy, learning disability or mental illness.

That said, the Department and NHID have indicated, in Waiver Application response to state-level questions and concerns, that:

> Although NHHPP enrollees will use the QHP appeals process, rather than the Medicaid fair hearing process, to appeal denials of coverage for benefits covered by the QHP, NHHPP enrollees will receive the full set of Medicaid-required protections throughout the appeals process. For example, NHHPP enrollees will have the ability to testify in person during the external review and NHHPP will have the protections of aid continuing. *(Waiver Application, page 112, response 11.)*

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[4] 42 C.F.R. §431.205, et seq.

[5] Goldberg v. Kelly, 397 U.S. 254 (1970)

We urge CMS to engage in thorough exploration with DHHS and NHID to ensure that the QHP appeals process for NHHPP enrollees fully complies with all Medicaid fair hearing requirements, and that such QHP process requirements are memorialized in writing in a way that assures DHHS accountability for the requirements to NHHPP enrollees. If that is not possible, we urge you to require New Hampshire to provide NHHPP enrollees with a Medicaid fair hearing process concerning QHP benefits.

4. *QHP Health Care Provider Network Adequacy and MCO QHP Auto-Assignment.*

In light of New Hampshire's first-year Marketplace experience of Anthem's limited health care provider network[6], we have been concerned about how DHHS and NHID will ensure that certified QHPs provide Premium Assistance Program ("PAP") enrollees with access to care that is comparable to the access available to the general population in the enrollee's geographic area, as required by federal Medicaid law[7].

We generally support and appreciate the QHP auto-assignment provisions in the draft Waiver application, and we are grateful for the provision that provides PAP enrollees who have been auto-assigned to a QHP with sixty (60) days to select a different QHP, if desired. However, from an enrollee and provider network adequacy perspective, we are concerned about a potentially harmful consequence of auto-assignment as it relates to New Hampshire's Medicaid managed care organizations (MCOs).

The NHHPP authorizing statute (SB 413) and proposed Waiver provide that when a person is determined to be PAP eligible and is a Bridge Program enrollee, if his or her MCO is offering a certified QHP, the enrollee will be auto-assigned to the qualified health plan offered by his or her MCO. We appreciate that the good faith intention of this provision is to ensure that individuals currently enrolled in the Bridge Program retain continuity of care and coverage. But we are concerned that MCO QHP auto-assignment could have the opposite effect.

Because the network adequacy standards for private insurance and the Marketplace are different than they are for Medicaid, and because the economics of private market provider networks also are different than they are for Medicaid, either or both of New Hampshire's MCOs may end up offering certified QHPs with health care provider networks that are more limited than their Medicaid managed care networks.

For example, if one or both MCOs offer certified QHPs with health care provider networks that resemble Anthem's current Marketplace network, there is genuine risk that Bridge Program enrollees could be auto-enrolled in an MCO-offered QHP that does not include their health care provider/s at all.

DHHS and NHID have now indicated, in Waiver Application responses to stakeholder questions and concerns at the state level, that:

> SB 413 requires that individuals enrolled in an MCO will be auto-assigned to the QHP offered by their MCO, if one is offered. The Department of Health and Human Services has interpreted this provision as requiring that individuals be auto-assigned

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[6] Anthem was the sole health insurance carrier on New Hampshire's federally-facilitated Marketplace in 2014, and its health care provider network included only 16 of the 26 community hospital systems, and their attendant primary care provider networks, in the Granite State.

[7] Social Security Act § 1902(a)(30)(A) / 42 U.S.C. § 1396a(a)(30)(A)

to the QHP offered by their MCO, *if that QHP is offered in the individual's region.* The State will not auto-assign an individual to a QHP unless that QHP is approved to be offered in the individual's county. *(Waiver Application, page 114-115, response 22.)*

All QHP networks are subject to prior review under state and federal network adequacy standards as part of the QHP certification process. These standards require that all covered persons have access to a network of primary care, specialist and institutional providers that is sufficient in number, type and geographic location to ensure that all covered health care services are available to covered persons without unreasonable delay. Insurance carriers are responsible for maintaining adequate networks on an ongoing basis, a requirement that is enforced by the NHID. The State will ensure that the QHP networks meet the requirements of the Social Security Act § 1902(a)(30)(A). As part of the State's evaluation, it will also assess whether individuals had sufficient access to care. *(Waiver Application, page 116, response 27.)*

Under the private market network adequacy standards, if a health carrier's network is insufficient with respect to a particular service in a county where the plan is offered, the carrier must cover services provided by a non-participating provider at no greater cost to the covered person than if the services were obtained from a participating provider. *(Waiver Application, page 116, response 28.)*

We are grateful for and encouraged by the DHHS and NHID responses to public comment and to stakeholder questions and concerns. However, in light of the transportation issues and challenges faced by NHHPP-eligible adults (all of whom are at lower-incomes, from 0% to 138% of the Federal Poverty Level) and the geographic size of New Hampshire counties, we remain concerned that the proposed 'county standard' (auto-assignment if the 'QHP is approved to be offered in the individual's county'), for provider network adequacy in the context of MCO auto-assignment, may still result in care disruption for NHHPP enrollees.[8]

To ensure compliance with Medicaid law concerning adequate access to care, and to prevent care disruption for Bridge Program enrollees, we urge CMS to consider requiring DHHS:

- To implement a network adequacy standard, in the context of MCO auto-assignment, that is more refined than the articulated 'county standard' (see above); and/or
- To require that, for Bridge Program enrollees, any notice of auto-assignment to their MCO-offered QHP must be provided at least sixty days in advance of January 1, 2016, affording the enrollee the opportunity to select and enroll in a different (and provider network-appropriate) QHP for his or her Premium Assistance Program coverage that begins on January 1, 2016.

5. *Wellness Programs.*

While there is no mention of wellness programs in New Hampshire's proposed Waiver, during the state-level public process and in response to public comment, DHHS indicated that:

Consistent with SB 413, the State intends to provide wellness programs in addition to – not in lieu of – cost-sharing to promote personal responsibility. *(Waiver Application, page 110, response 3.)*

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[8] This appears to be the same private insurance network adequacy standard that has been problematic for patients in particular geographic areas in the context of New Hampshire's single-carrier federally-facilitated Marketplace in 2014, and that would promise to be troublesome for lower-income NHHPP enrollees.

VOICES supports and encourages pragmatic and workable, evidence-based Medicaid wellness programs that utilize participant rewards and/or incentives to promote health and well-being. However, we are concerned that wellness programs employing penalties are harmful to lower-income and vulnerable populations like NHHPP enrollees.

On behalf of current and future NHHPP enrollees, we urge CMS to resist New Hampshire efforts, if any, to implement a wellness program employing any participant penalties that may impede health care access and/or impair coverage affordability for Premium Assistance Program enrollees, who already face a variety of unique challenges and barriers due to income level, socio-economic vulnerabilities, health status and/or demographics.

We thank CMS for the opportunity to submit these Comments on New Hampshire's Section 1115 Premium Assistance Waiver Application. We look forward to working with you, DHHS, and NHID to ensure the successful implementation of the Premium Assistance Program and the continued success of the NHHPP. If you have any questions, please do not hesitate to contact me at 603.491.1924 or Tom@NHVoicesforHealth.org.

Sincerely,

Thomas G. Bunnell, Esq.
Policy Specialist